

TESTIMONY TO  
SENATE INSURANCE COMMITTEE  
S.B. 248 (S-3)  
April 21, 2015

I am Michael Dabbs, President of the Brain Injury Association of Michigan and Secretary of CPAN and on behalf of the members of both organizations wish to express our opposition to S.B. 248 (S-3).

Let me be clear that we are not opposed to reform; but rather, would urge you to take the time necessary to learn of the consequences this legislation would likely precipitate.

Specifically, I want to address the Attendant Care portion of this bill. Included with this testimony is the BIAMI Attendant Care Position Paper, which is working document reflecting what we believe are some needed reforms. You will note that our suggested changes are aimed at ensuring what is best for the survivor of a brain injury, their families, as well as ensuring that insurance companies can better document the care provided and that their payment is for the only the services as prescribed. Let me add that we have shared these concepts with the insurance industry during our discussions of the past few months and they seem to feel it was a good framework from which to work.

In addition, please consider the following:

1. Unlike any other injury, a person with a serious brain injury in nearly all instances is unable to direct their care. The persons' brain injury affects their cognitive abilities, behavioral responses, and emotions. The significance of this point is that the survivor of a brain injury may not respond, or respond inappropriately to non-family care givers.
2. Multiple caregivers from an agency can exacerbate this issue. Having changes in personnel, week-to-week; month-to-month is disruptive to the individual and to the family. The ability of agency caregivers to get to the survivors' home also is problematic in winter conditions, especially in more rural settings.
3. The irony of the proposed changes to Attendant Care is that they will end up increasing the cost to insurance companies by forcing families into sub-acute care facilities, or possibly nursing homes, or having to utilize a Home Care Agency – all of which are more costly options. And we all know that more cost to insurance companies' means higher premiums we pay. I truly do not believe this consequence is what you want to achieve with your efforts to reform the auto no-fault insurance system.

Let me ask you to consider these serious flaws in the current bill:

- A. Sec. 3107C (1)(A): Different levels of care and in different parts of the state dictate that state government should not be in the business of dictating prices. The irony is

while the author of this bill may have envisioned this as a way to control costs, it actually may result in greater costs in some instances. Here's an example, a physician may prescribe that monitoring of a patient could be done using something as simple as a baby monitor; or perhaps with a camera and yet this bill would require an individual be paid \$15.00 per hour. In other instances, a family member may be highly skilled and could provide treatment for their love-one on a ventilator. Does it even sound reasonable to pay \$15.00 per hour for this specialized skill? I would challenge all of you to consider a more reasonable approach to this issue, as recommended in our position paper.

- B. Sec. 3107C (2): On initial reading of this section the limitation of 24 hours per day would seem reasonable – and for most cases, it may be. However, there are individuals with severe brain injuries who have limited to no ability to move their body; and certainly many spinal cord injured survivors who will need to be transferred from their bed, to a chair, to the toilet or shower, etc., that require at least two persons to move them. This is typical protocol in hospitals and there is nothing different in the home, should this be necessary. Thus, this needs to be changed.
- C. Sec. 3107C (5): Insurance companies already do “medical reviews” – the problem is that often times medical review doctors determine a different level of care than the survivors’ physician. This hastily worded section needs much greater attention to language.

We have heard some legislators say that costly insurance premiums are the biggest complaint they hear. So let me ask you, where in this bill does it direct the insurance industry to reduce their premiums? Maybe you would be wise to consider the approach the Detroit City Council took in demanding the Red Wings put in writing what they would do in terms of rehabilitating a hotel on the site of their new arena. Let's see some direction in this legislation directing insurance companies to reduce their premiums.

Lastly, I would remind the committee that CPAN and BIAMI have a joint lawsuit against the MCCA for their failure to be fully transparent that is currently in the MI. Supreme Court. If you believe as this bill's sponsor did that there is enough wrong with the MCCA to ultimately eliminate it and establish a new MCCC entity; doesn't it make sense you would want to know the findings of the court before you launch into a completely new organization?

Again, we are opposed to S.B. 248 (S-3) as written. A more deliberate approach with people from both sides of this issue advising you is required, if you truly want to reform the auto no-fault insurance system. Otherwise, you will create unintended consequences that will take years of litigation to correct and the only one who loses will be survivors of a car crash. Perhaps you would be wise to think about this bill from your personal perspective or your loved ones, if they were involved in a serious car crash, is this truly the insurance regulations that you would want them subjected to? I strongly recommend you vote NO on this bill.

Michael F. Dabbs  
President, Brain Injury Association of Michigan  
Secretary, CPAN

*C: Brain Injury Association of Michigan Attendant Care Position Paper, Working DRAFT*

*Our Mission: To enhance the lives of those affected by brain injury through education, advocacy, research, and local support groups, and to reduce the incidence of brain injury through prevention.*

# BRAIN INJURY ASSOCIATION OF MICHIGAN

## ATTENDANT CARE

### POSITION PAPER

March 30, 2015

**THIS IS A WORKING DOCUMENT INTENDED TO IDENTIFY KEY AREAS OF ATTENDANT CARE AS A GENERAL FRAMEWORK FOR DISCUSSION AND IS NOT INTENDED TO BE ALL INCLUSIVE**

**PRINCIPLE:** It is our belief that for the injured person medical care is paramount and that ensuring the patient receives all care deemed reasonably necessary should be the central focus of discussions on this topic. In nearly all cases, care provided by family members who are appropriately trained to deliver the necessary care, who receive oversight by a trained physician or clinician, is reasonably necessary for the patient's care, recovery or rehabilitation.

**PHYSICIAN DETERMINATION AND OVERSIGHT:** Decisions regarding the appropriateness of in-home attendant care, as well as the type, intensity, frequency, level of care, and supervision required, should be made by the treating physician in concert with other clinicians and family members following a comprehensive assessment of the individual's care needs. In-Home Care Plans for attendant care situations for persons with a brain injury are recommended. In-Home Care Plans should have at least annual reviews of the plan; or more frequently if health care needs change. The caregiver's competence to provide the care needed should be monitored as directed in the care plan. Care determination and oversight will be retroactive in those cases with a demonstrated need for review.

**CAREGIVER TRAINING:** Appropriate training for all caregiver's is required prior to patient's discharge to a home setting. Completion of training can be documented by either a physician or RN – with periodic review of caregiver competency. Caregiver training will be retroactive in all cases- family members may provide proof of competency to physician or RN if previously trained.

**HOURLY CARE RECOMMENDATIONS:** Generally, no single family member should be responsible for 24/7 care; however, 24/7 care can be rendered by a multiple family members who are appropriately trained. Furthermore, it is recommended that no one person provide care for more than 16 consecutive hours with at least a break of 8 hours. Availability of and use of monitoring devices and other technologies will be considered in determining care needed. Care restrictions are retroactive in most cases unless there is an identified outlier scenario.

**AFFIDAVIT OF CARE:** Family is to certify that care prescribed has been rendered. Affidavit to be provided for all current and future cases.

**REIMBURSEMENT OF CARE:** The reimbursement rate should be 90 percent of the commercial rate for the defined geographic region for the level of care that is required. In absence of a rate standard for the injured person's region, then 90 percent of the commercial rate for the state for the level of care provided will be used. Those patients whose caregivers are receiving negotiated levels of reimbursement should not be required to accept lower rates due to changes in the statutory scheme.